



## MONTANA STATE HOSPITAL POLICY AND PROCEDURE

### Discharge Planning

**Effective Date:** April 21, 2016

**Policy #:** AD-04

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- I. PURPOSE:** To specify discharge planning procedures to ensure that discharge planning begins at the time of admission and is updated throughout the duration of hospitalization.
- II. POLICY:** Each person admitted to Montana State Hospital (MSH) will have an individualized aftercare plan specifying services and referrals needed upon discharge. MSH staff will work closely with the patient, the patient's family/significant others and appropriate community agencies to ensure continuity of care is addressed and Montana state statute requirements are met.
- III. DEFINITIONS:**
  - A. Community Reentry Plan – A document that provides basic information to begin discharge planning procedures early in the patient's stay.
  - B. Aftercare Plan – A document that addresses major aspects of a patient's living situation and treatment needs following hospitalization.
  - C. Discharge Summary – A recapitulation of the patient's hospital course including a summary of the aftercare plan.
- IV. RESPONSIBILITIES:**
  - A. Social Worker– the staff member who is assigned primary responsibility for coordinating aftercare planning procedures.
  - B. Discharge Technician – a position within the Social Work department that assists in the discharge process by ensuring that tasks related to discharge are completed and critical information is tracked and reported.
- V. PROCEDURE:**
  - A. **COMMUNITY REENTRY PLAN**
    - 1. Each patient admitted to MSH will have a Community Reentry Plan developed by that patient's designated Social Worker as soon as practical. The Community Reentry Plan will focus on the individual needs of the patient and will be formulated with the participation of the patient or guardian. Also, participation

will include available family members, significant others and related community agencies.

2. The Community Reentry Plan will be completed on a form developed by MSH (Attachment A) and will identify a community mental health contact person and a MSH Social Worker in order to facilitate communication within 10 days of patient's admission. If the Social Worker obtains authorization from the client, this plan will be faxed to the community. A description of each contact related to discharge planning will be entered in the patient's medical record.
3. It is recognized that discharge planning will be an ongoing process during a person's hospitalization and that changes are likely to occur in the discharge plan. The discharge plan will be regularly and systematically reviewed by the patient, the Social Worker and treatment team with changes made to reflect the needs and desires of the patient. These changes must be noted in the progress notes.

When a patient is transferred to another unit or the Social Worker is changed, the new Social Worker should be brought up-to-date at the earliest opportunity by the previous Social Worker.

5. Every effort should be made to involve the community mental health contact person or other aftercare providers in the discharge plan review process. Aftercare providers should be informed whenever significant modifications to a patient's discharge plan are made. This can be done through written, e-mail, fax, or telephone communications.
6. A packet of clinical information will be sent, using the MSH Referral for Aftercare Form (attachment B). The packet shall include:
  - a. Social History or Interim History
  - b. Most recent Psychiatric Evaluation
  - c. Relevant Laboratory results/TB exam
  - d. 60 days of Progress Notes
  - e. Nursing Assessment
  - f. Recent Physical Examination Summary, including Medical Consultations
  - g. Forensic Review Board Report if (if relevant)

It is the Social Worker's responsibility to ensure that up-to-date information is sent to aftercare agencies.

7. The Social Work Discharge Process will be followed by the Discharge Technician to facilitate a safe discharge that ensures continuity of care is addressed and Montana State Statute requirements are met.

B. AFTERCARE PLAN

1. Near the end of hospitalization, work pertaining to discharge planning will culminate with the completion of the Aftercare Plan. The Aftercare Plan (Attachment B) serves four functions:
  - a. To provide identifying information on the patient that the aftercare provider(s) may find helpful in the provision of services.
  - b. To provide specific information regarding the patient's discharge plan; i.e., where the person will live, source of income, medical needs and scheduled appointments.
  - c. To provide information that the community mental health program may find helpful in developing a community treatment plan; i.e., major problems, needs, concerns, strengths, and personal goals.
  - d. To provide recommendations by MSH staff for aftercare services.
2. The Aftercare Plan is developed through a cooperative effort involving the patient, the MSH Social Worker, the family and significant others of the patient, the community mental health contact person, and other aftercare service providers. The Aftercare is completed in TIER. Upon completion of the Aftercare, the Social Worker will review the Aftercare Plan with the patient prior to discharge. The Social Worker will fax Aftercare Plan to the community mental health center, community LIP and other agencies within 48-24 hours before discharge. A copy of the Aftercare Plan is placed in the patient's medical record filed under the discharge tab. The Social Worker will save the final copy of Aftercare Plan in TIER by initialing the document. If the patient has a Guardian, the Aftercare Plan will be reviewed with the Guardian and the Guardian must be provided a copy of the Aftercare Plan. The Aftercare Plan may also be mailed. All applicable HIPPA regulations must be followed when communicating information to aftercare providers or other persons.

C. DISCHARGE INSTRUCTION SHEET

The Discharge Instruction Sheet will be initiated in TIER by licensed nursing staff and completed at the time of discharge. The Social Worker completes and electronically signs the lower portion of this form to indicate scheduled appointments. This document will be reviewed with the patient by the licensed nursing staff prior to discharge. The licensed nurse will sign the document with the patient. A copy will be provided to the patient and a copy will be placed in the patient's MSH medical record.

D. DISCHARGE SUMMARY

A discharge summary will be completed by the LIP within 15 days of the patient's discharge and sent to appropriate aftercare providers (see MSH policy HI-04, Discharge Summary).

**VI. REFERENCES:** 53-21-180 M.C.A.

**VII. COLLABORATED WITH:** Medical Director, Hospital Administrator, Social Work Quality Improvement Team.

**VIII. RESCISSIONS:** #AD-04, *Discharge Planning*, dated March 12, 2012; #AD-04, *Discharge Planning*, dated November 9, 2009; #AD-04, *Discharge Planning Policy* dated August 28, 2006; #AD-04, *Discharge Planning Policy* dated September 8, 2003; #AD-02, *Discharge Policy*, dated May 15, 2001

**IX. DISTRIBUTION:** All hospital policy manuals.

**X. ANNUAL REVIEW AND AUTHORIZATION:** This policy is subject to annual review and authorization for use by either the Administrator or the Medical Director with written documentation of the review per ARM § 37-106-330.

**XI. FOLLOW-UP RESPONSIBILITY:** Director of Clinical Services

**XII. ATTACHMENTS:**

A. Initial Treatment Plan & Community Reentry Plan

B. Montana State Hospital Referral for Aftercare

\_\_\_\_\_/\_\_\_\_/\_\_\_\_  
John W. Glueckert

Date

Hospital Administrator

\_\_\_\_\_/\_\_\_\_/\_\_\_\_  
Thomas Gray, MD

Date

Medical Director

# MONTANA STATE HOSPITAL INITIAL TREATMENT PLAN

Document/describe problems to be addressed and corresponding goals. Suggestions below are guidelines only, not complete lists.

Date	Immediate Problem	Short Term Objective	Intervention	Date Resolved

**1. Risk to self**

- A. Tolerate distress safely
- B. Improved coping skills
- \*C. Participate in further assessment
  - ☐ Suicide/Self-harming
  - ☐ ULP

**2. Risk to others**

- A. Interact safely and appropriately with others
- B. Demonstrate willingness for redirection
- C. Express anger in an acceptable manner
- \* D. Participate in further assessment
  - ☐ Aggression/Violence

**3. Inability to care for self**

- A. Improved eating patterns
- B. Improved sleep patterns
- C. Improved hygiene
- D. Improved toileting
- E. Improve skin integrity

**4. Impaired coping skills**

- A. Learn about distress tolerance
- B. Actively participate in unit activities
- C. Develop a recovery plan
- \* D. Participate in further assessment
  - ☐ Trauma History/Sexual Behaviors
  - ☐ Co-Occurring History

**5. Altered thought process**

- A. Engage in behaviors which promote stability/discharge
- B. Improve medication knowledge and benefits
- C. Improve mood stability
- D. Improve orientation to time, place, and person

**6. Medical problems**

- A. Physiologic stability (CIWA, CINA)
- B. Tolerate medications
- C. Safe mobility
- D. Pain control allows for ADL's
- \* E. Participate in further assessment
  - ☐ Nicotine dependence
  - ☐ Other medical complications \*

Check appropriate Risk Precaution below and flag unit board. Admit Status (indicate change in status by date)

**Status**

<input type="checkbox"/> Emergency Detention	<input type="checkbox"/> COE	<input type="checkbox"/> Suicide/Self Abuse (S)	<input type="checkbox"/> Substance Use Disorder (M1)	<input type="checkbox"/> Unit Restricted
<input type="checkbox"/> Court Ordered Detention	<input type="checkbox"/> UTP	<input type="checkbox"/> ULP	<input type="checkbox"/> Falls (M2)	<input type="checkbox"/> Escort Off Unit
<input type="checkbox"/> Voluntary	<input type="checkbox"/> GBMI	<input type="checkbox"/> Aggression/Violence (A)	<input type="checkbox"/> Seizures (M3)	<input type="checkbox"/> Pending Legal Process
<input type="checkbox"/> Involuntary	<input type="checkbox"/> NGMI	<input type="checkbox"/> Sexual Behaviors (X)	<input type="checkbox"/> Medical (M4)	<input type="checkbox"/> Other
<input type="checkbox"/> Vol -D	<input type="checkbox"/> Tribal	<input type="checkbox"/> Fire Safety (F)		

**Signatures**

Signature _____	Date/Time _____	Signature _____	Date/Time _____
Signature _____	Date/Time _____	Signature _____	Date/Time _____
Signature _____	Date/Time _____	Signature _____	Date/Time _____
Patient Signature _____	Date/Time _____		

**NAME:** \_\_\_\_\_ **HOSPITAL NUMBER:** \_\_\_\_\_ **Unit Placement** \_\_\_\_\_

**MONTANA STATE HOSPITAL  
COMMUNITY REENTRY PLAN**

**NAME:** \_\_\_\_\_ **HOSPITAL NUMBER:** \_\_\_\_\_ **Unit Placement** \_\_\_\_\_

Admission Date: \_\_\_\_\_ Commitment Status: \_\_\_\_\_ Estimated Discharge Date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Social Worker: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Mental Health Services prior to admission: \_\_\_\_\_

Discharge Criteria: \_\_\_\_\_

Plan: \_\_\_\_\_

Person's interest in returning to community: \_\_\_\_\_

**FUNDING**

☐ MHSP Eligibility Dates \_\_\_\_\_ to \_\_\_\_\_

☐ Medicaid ☐ Medicare ☐ VA ☐ Private Pay/Other ☐ Funding Pending \_\_\_\_\_ ☐ No Known Funding

Family/Friends/Advocates: \_\_\_\_\_

Other Comments: \_\_\_\_\_

Referred to: \_\_\_\_\_ Social Worker Signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Initial Discharge/Aftercare Plan & Admission Document Faxed to # \_\_\_\_\_ Date Faxed: \_\_\_\_\_

**To be completed by community provider:**

Recommended Aftercare

☐ NO, reason: \_\_\_\_\_

☐ YES, for what services: \_\_\_\_\_

☐ Maybe, other needs: \_\_\_\_\_

☐ Group Home

☐ Case Management

☐ Medication Follow Up

☐ Nursing Home

☐ Adult Foster Care

☐ Day Treatment

☐ Transitional Care

☐ Intensive Group Home

☐ PACT

☐ DD Services

☐ Depo Meds

☐ Other \_\_\_\_\_

☐ CLO

☐ Individual Therapy

☐ Chemical Dependency Tx

Provider Signature: \_\_\_\_\_ Date Faxed to MSH: \_\_\_\_\_

MONTANA STATE HOSPITAL  
REFERRAL FOR AFTERCARE

Date: \_\_\_\_\_

Aftercare Provider: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Unit: \_\_\_\_\_

Social Worker: \_\_\_\_\_ Phone #: 693-\_\_\_\_\_

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**Funding:**

☐ MHSP

Eligibility dates \_\_\_\_\_ to \_\_\_\_\_.

☐ Medicaid

☐ Private Pay

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**Services Requested:**

☐ Group Home

☐ Case Management

☐ Adult Foster Care

☐ Day Treatment

☐ PACT

☐ Medication Follow-up

Estimated length of time to discharge: \_\_\_\_\_.

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**To be completed by the Community Provider:**

Date of review: To be completed by the Community Provider:

Date of review: \_\_\_\_\_

Accepted for Services: Yes ☐ No ☐

If not accepted, barriers to acceptance: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MONTANA STATE HOSPITAL  
AFTERCARE PLAN**

**NAME:**

**DATE:**

**HOSPITAL #:**

**D.O.B.:**

**TYPE OF COMMITMENT:**

**COUNTY OF ADMISSION:**

**ADM. DATE:**

**DIAGNOSIS:** Axis I:  
Axis II:  
Axis III:  
Axis IV:  
Axis V:

**TYPE OF RELEASE:**

**DISCHARGE DATE:**

**NAME AND ADDRESS OF INTERESTED RELATIVE/FRIEND:**

Phone:

**DISCHARGE ADDRESS/LIVING ARRANGEMENTS:**

Phone:

**DISCHARGE ARRANGEMENTS THAT HAVE BEEN MADE:**

Travel Arrangements:

Follow-up Appointments:

Other Community Contacts:

**MAJOR PROBLEMS/NEEDS/CONCERNS:**

**PATIENT'S PERSONAL GOALS:**

**PRESENT FINANCIAL NEEDS AND SOURCE OF INCOME:**

**NAME AND ADDRESS OF REP. PAYEE:**

**PHONE:**



**AFTERCARE SERVICES RECOMMENDED BY MONTANA STATE HOSPITAL:**

\_\_\_\_ Psychiatric/Medication Follow-up    \_\_\_\_ Case Management    \_\_\_\_ Therapy    \_\_\_\_ Day Treatment  
\_\_\_\_ PACT Team Services    \_\_\_\_ Group Home Placement    \_\_\_\_ Adult Foster Care Placement  
\_\_\_\_ In-patient CD Treatment [3.5 Level]    \_\_\_\_ Residential CD Treatment [3.1 Level]  
\_\_\_\_ Intensive Out-Patient CD Treatment    \_\_\_\_ Out-Patient CD Treatment

**PATIENT'S MEDICAL NEEDS:**

**PRESENT MEDICATIONS:**

**MEDICATION TO BE SUPPLIED BY MSH UPON DISCHARGE:**

**MEDICATIONS WILL NEED TO BE RENEWED BY (DATE):**

**REPORTS ENCLOSED WITH AFTERCARE PLAN:**

____ Social History	____ Nursing Assessment
____ Psychiatric Evaluation	____ Lab Results/RB exam
____ Psychological	____ Progress Notes
____ Dr. Orders	____ Rehabilitation Therapy Evaluation
____ History & Physical	____ Current Commitment Papers
____ Treatment Plan	
____ Other:	

**REFERRED BY:**

**SENT TO:**

Montana State Hospital  
Warm Springs, Montana 59756  
(406) 693-

ATTENDING LIP: \_\_\_\_

MONTANA STATE HOSPITAL  
DISCHARGE/HOME VISIT INSTRUCTIONS

NAME: \_\_\_\_\_ DATE OF DISCHARGE/H.V.: \_\_\_\_\_

**MEDICATIONS**

MEDICATION NAME	DOSE	TIME/ INSTRUCTIONS	INFO HANDOUT	
			YES	NO

☐ Instructed on taking medication(s): verbalizes an/or demonstrates understanding  
Medication provided: ☐ 2 weeks supply ☐ Other \_\_\_\_\_  
Diet ☐ Regular ☐ Other \_\_\_\_\_ ☐ Handout Given

**Discharge/Home Visit Arrangements:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other Instructions: **No alcohol or illegal drug use. No access to firearms or ammunition.**  
\_\_\_\_\_  
\_\_\_\_\_

**REFERRALS & APPOINTMENTS**

Name	Address	Phone	Date	Time

\_\_\_\_\_  
Social Worker's Name                      Patient's Signature                      Nurse's Signature  
Original: Health Information                      Copy: Patient                      \_\_\_\_\_  
\_\_\_\_\_  
Date                      Date                      Date

## **MEDICATION INSTRUCTIONS**

1. Learn the name of the medication and the reasons why you are taking the medication.
2. Take the medication at the times and in the amount prescribed.
3. Do not offer your medication to anyone else. It has been especially prescribed for you and may be harmful to someone else.
4. Keep all medications securely away from the reach of children.
5. Certain medications become outdated, at which time they may be ineffective or even harmful. If your medication is more than several months old, ask your pharmacist if it is safe and effective.
6. Do not mix medications in one container. Keep each medication in its own container.
7. Alcohol should be avoided when taking medication.
8. Medicine may produce an allergic or unanticipated reaction, even in people who are not known to be allergic or who have taken the drug before. Contact your physician if you experience rash, fever, vomiting, diarrhea, or other unusual symptoms.